		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028605

Facility Name: Rest Haven West Christian Nursing Center

Address: 3450 Saratoga Avenue (Number) Downers Grove (City) 60515 (Zip Code)

County: DuPage

Telephone Number: (630) 969-2000 **Fax #** (630) 969-2148

IDPA ID Number: 362382853003

Date of Initial License for Current Owners: 05/01/84

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-4581
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,136	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	88,206	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,769	20,648	10,807	48,224	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		26,402		26,402	12
13	DD 16 OR LESS					13
14	TOTALS	16,769	47,050	10,807	74,626	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.60%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 10,807

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	674,565	126,278	19,642	820,485		820,485		820,485			1
2	Food Purchase		457,703		457,703		457,703	(12,395)	445,308			2
3	Housekeeping	180,318	34,367		214,685		214,685		214,685			3
4	Laundry	40,570	79,816		120,386		120,386	(3,511)	116,875			4
5	Heat and Other Utilities			233,142	233,142		233,142	12,327	245,469			5
6	Maintenance	199,760		160,470	360,230		360,230	(25,924)	334,306			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,095,213	698,164	413,254	2,206,631		2,206,631	(29,503)	2,177,128			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,707,531	260,122	1,096,542	4,064,195		4,064,195		4,064,195			10
10a	Therapy			778,565	778,565		778,565		778,565			10a
11	Activities	305,305	18,132	1,078	324,515		324,515		324,515			11
12	Social Services	128,316		2,168	130,484		130,484		130,484			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,141,152	278,254	1,892,753	5,312,159		5,312,159		5,312,159			16
	C. General Administration											
17	Administrative	59,527		876,000	935,527		935,527	(795,192)	140,335			17
18	Directors Fees											18
19	Professional Services			28,610	28,610		28,610	11,938	40,548			19
20	Dues, Fees, Subscriptions & Promotions			31,339	31,339		31,339	9,777	41,116			20
21	Clerical & General Office Expenses	409,092	25,911	29,653	464,656		464,656	470,428	935,084			21
22	Employee Benefits & Payroll Taxes			903,599	903,599		903,599		903,599			22
23	Inservice Training & Education							301	301			23
24	Travel and Seminar			5,239	5,239		5,239	21,304	26,543			24
25	Other Admin. Staff Transportation							2,067	2,067			25
26	Insurance-Prop.Liab.Malpractice			201,331	201,331		201,331	13,147	214,478			26
27	Other (specify):* **Allocated Benefits**							116,173	116,173			27
28	**TOTAL General Administration**	468,619	25,911	2,075,771	2,570,301		2,570,301	(150,057)	2,420,244			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,704,984	1,002,329	4,381,778	10,089,091		10,089,091	(179,560)	9,909,531			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rest Haven West Christian Nursing Center #0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			676,729	676,729		676,729	185,746	862,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			437,854	437,854		437,854	(139,691)	298,163			32
33	Real Estate Taxes			21,216	21,216		21,216	(12,256)	8,960			33
34	Rent-Facility & Grounds							1,546	1,546			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,135,799	1,135,799		1,135,799	35,345	1,171,144			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		884,822		884,822		884,822		884,822			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,040	80,040		80,040		80,040			42
43	Other (specify):* Nonallowable Costs			288,269	288,269		288,269	(288,269)				43
44	**TOTAL Special Cost Centers**		884,822	368,309	1,253,131		1,253,131	(288,269)	964,862			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,704,984	1,887,151	5,885,886	12,478,021		12,478,021	(432,484)	12,045,537			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,143)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,511)	4		8
9	Non-Straightline Depreciation	88,471	30		9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(181,362)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,172)	43		24
25	Fund Raising, Advertising and Promotional	(131,872)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(36,876)	43		28
29	Other-Attach Schedule See Schedule 5A	(175,465)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (450,028)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,544		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,544		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (432,484)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven West Christian Nursing Center
Provider #: 0028605
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Residents Welfare	(8,470)	43
Miscellaneous Income Offset	(4,755)	2
Telephone Income Offset	(12,397)	21
Barber Income Offset	(18,725)	21
Day Care Income Offset	(23)	21
Church/Civic	(970)	43
Interehab Physiatry	(69,525)	43
Disallow Real Estate Tax	(21,216)	33
Medicare Laboratory	(28,574)	43
Medicare X-Ray	(10,810)	43
	(175,465)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven West Christian Nursing Center **#** 0028605 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,143)	503	0	0	0	0	0	0	0	0	0	(7,640)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,511)	0	0	0	0	0	0	0	0	0	0	(3,511)	4
5	Heat and Other Utilities	0	12,327	0	0	0	0	0	0	0	0	0	12,327	5
6	Maintenance	0	(25,924)	0	0	0	0	0	0	0	0	0	(25,924)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,654)	(13,094)	0	0	0	0	0	0	0	0	0	(24,748)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(795,192)	0	0	0	0	0	0	0	0	0	(795,192)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,938	0	0	0	0	0	0	0	0	0	11,938	19
20	Fees, Subscriptions & Promotions	0	11,442	0	0	0	0	0	0	0	0	0	11,442	20
21	Clerical & General Office Expenses	0	501,573	0	0	0	0	0	0	0	0	0	501,573	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	301	0	0	0	0	0	0	0	0	0	301	23
24	Travel and Seminar	0	19,639	0	0	0	0	0	0	0	0	0	19,639	24
25	Other Admin. Staff Transportation	0	2,067	0	0	0	0	0	0	0	0	0	2,067	25
26	Insurance-Prop.Liab.Malpractice	0	13,147	0	0	0	0	0	0	0	0	0	13,147	26
27	Other (specify):*	0	116,173	0	0	0	0	0	0	0	0	0	116,173	27
28	**TOTAL General Administration**	0	(118,912)	0	0	0	0	0	0	0	0	0	(118,912)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,654)	(132,006)	0	0	0	0	0	0	0	0	0	(143,660)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	88,471	97,275	0	0	0	0	0	0	0	0	0	185,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(181,460)	0	41,769	0	0	0	0	0	0	0	0	(139,691)	32
33	Real Estate Taxes	0	0	8,960	0	0	0	0	0	0	0	0	8,960	33
34	Rent-Facility & Grounds	0	0	1,546	0	0	0	0	0	0	0	0	1,546	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(92,989)	97,275	52,275	0	0	0	0	0	0	0	0	56,561	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(169,920)	0	0	0	0	0	0	0	0	0	0	(169,920)	43
44	**TOTAL Special Cost Centers**	(169,920)	0	0	0	0	0	0	0	0	0	0	(169,920)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(274,563)	(34,731)	52,275	0	0	0	0	0	0	0	0	(257,019)	45

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home	100	Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
		Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	Tinley Park	Management Co.
				Providence Home Health Care	Tinley Park	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 503	$ 503	1
2	V	5	Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	12,327	12,327	2
3	V	6	Maintenance	32,805	Rest Haven Illiana Christian Convalescent Home	100.00%	6,881	(25,924)	3
4	V	17	Administrative	876,000	Rest Haven Illiana Christian Convalescent Home	100.00%	80,808	(795,192)	4
5	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	11,938	11,938	5
6	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	11,442	11,442	6
7	V	21	Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	501,573	501,573	7
8	V	23	Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	301	301	8
9	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	19,639	19,639	9
10	V	25	Other admin. staff transport.		Rest Haven Illiana Christian Convalescent Home	100.00%	2,067	2,067	10
11	V	26	Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	13,147	13,147	11
12	V	27	Mgmt. allocation of benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	116,173	116,173	12
13	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	97,275	97,275	13
14	Total			$ 908,805			$ 874,074	$ * (34,731)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 41,769	$ 41,769	15
16	V	33	Real estate taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	8,960	8,960	16
17	V	34	Rent - facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	1,546	1,546	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 52,275	$ * 52,275	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5	N/A - Voluntary Board with no compensation. See attached Schedule 7A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Accumulated cost	70,996,213	15	$ 3,030	$	11,767,413	$ 503	1
2	5	Utilities	Accumulated cost	70,996,213	15	74,367		11,767,413	12,327	2
3	6	Maintenance	Accumulated cost	70,996,213	15	41,515		11,767,413	6,881	3
4	19	Professional services	Accumulated cost	70,996,213	15	72,028		11,767,413	11,938	4
5	20	Dues, fees & subscriptions	Accumulated cost	70,996,213	15	69,035		11,767,413	11,442	5
6	21	Clerical & gen. office - salary	Accumulated cost	70,996,213	15	2,699,260	2,699,260	11,767,413	447,394	6
7	21	Clerical & gen. office	Accumulated cost	70,996,213	15	326,877		11,767,413	54,179	7
8	23	Inservice training & education	Accumulated cost	70,996,213	15	1,814		11,767,413	301	8
9	24	Travel & seminar	Accumulated cost	70,996,213	15	118,491		11,767,413	19,639	9
10	25	Other admin. staff transport.	Accumulated cost	70,996,213	15	12,467		11,767,413	2,067	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	70,996,213	15	79,324		11,767,413	13,147	11
12	27	Mgmt. allocation of benefits	Accumulated cost	70,996,213	15	700,904		11,767,413	116,173	12
13	30	Depreciation	Accumulated cost	70,996,213	15	586,888		11,767,413	97,275	13
14	32	Interest	Accumulated cost	70,996,213	15	252,004		11,767,413	41,769	14
15	33	Real estate taxes	Accumulated cost	70,996,213	15	54,062		11,767,413	8,960	15
16	34	Rent - facility & grounds	Accumulated cost	70,996,213	15	9,329		11,767,413	1,546	16
17										17
18	17	Administrative	Direct cost			720,689	720,689		80,808	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,822,084	$ 3,419,949		$ 926,349	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tax Exempt Bonds		X	Additions and renovations	Varies	2/26/97	$ 5,515,700	$	07/01/2012	0.0536	$ 354,978	1
2	Tax Exempt Bonds		X	Additions and renovations	Varies	11/01/04	9,450,000	9,450,000	10/31/2034	Variable	79,753	2
3	Notes		X	Facility Improvements	Varies	Various	763,564	1,113	Various	Variable	3,123	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 15,729,264	$ 9,451,113			$ 437,854	9
	B. Non-Facility Related*											
10								Allocated from Home Office			41,769	10
11								Interest income offset			(98)	11
12								Disallow non-care interest			(181,362)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (139,691)	14
15	TOTALS (line 9+line14)						$ 15,729,264	$ 9,451,113			$ 298,163	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$	2
3. Under or (over) accrual (line 2 minus line 1).		N/A $	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Allocated from home office**	8,960	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,960	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

Real estate taxes are allocated from a for-profit management company.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven West Christian Nursing Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028605

CONTACT PERSON REGARDING THIS REPORT Bill De Young

TELEPHONE (708) 342-8100 FAX #: (708) 342-8006

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-01-203-003-0000	New Home Office Building	$ 54,062.00	$ 8,960.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,062.00	$ 8,960.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,200	1984	$ 339,570	1
2					2
3	TOTALS	29,200		$ 339,570	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	241		1984	1962	$ 86,903	$	40	$	$	$ 86,903	4
5				1972	889,527	22,238	40	22,238		733,854	5
6				1976	34,742	869	40	869		27,808	6
7				1974	7,414	185	40	185		5,735	7
8				1975	55,878	1,397	40	1,397		41,910	8
	Improvement Type**										
9	Improvement			1976	4,115	103	40	103		2,987	9
10	Improvement			1977	33,527	838	40	838		23,464	10
11	Improvement			1980	6,049	151	40	151		3,775	11
12	Improvement			1981	7,380	185	40	185		4,440	12
13	Improvement			1983	22,839	571	40	571		12,562	13
14	Improvement			1984	253,714	9,250	40	9,250		166,653	14
15	Improvement			1985	297,491	7,437	40	7,437		148,740	15
16	Improvement			1986	275,406	6,885	40	6,885		130,815	16
17	Improvement			1987	24,035	601	40	601		10,818	17
18	Improvement			1988	509,896	12,747	40	12,747		216,699	18
19	Improvement			1989	4,381,420	109,536	40	109,536		1,752,576	19
20	Improvement			1989	90,660	2,267	40	2,267		36,272	20
21	Improvement			1990	155,196	3,880	40	3,880		58,200	21
22	Improvement			1991	5,021	126	40	126		1,764	22
23	Improvement			1992	75,453	1,886	40	1,886		24,518	23
24	Improvement			1993	26,281	657	40	657		7,884	24
25	Improvement			1994	16,231	405	40	405		4,455	25
26	Improvement			1995	128,962	3,224	40	3,224		30,628	26
27	Sign and landscaping			1996	4,764	119	40	119		1,012	27
28	Fence			1996	1,565	40	40	40		340	28
29	Renovate laundry and break rooms			1996	4,400	110	40	110		935	29
30	Whirlpool tubs			1996	20,200	505	40	505		4,292	30
31	Side rail			1996	2,293	57	40	57		485	31
32	Phone system			1996	35,085	877	40	877		15,277	32
33	Parking lot			1997	15,078	377	40	377		2,828	33
34	Landscaping			1997	10,839	271	40	271		2,032	34
35	Dining room renovation			1997	1,193	30	40	30		225	35
36	Hospitality room renovation			1997	34,830	871	40	871		6,532	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Activity / class room renovation	1997	$ 3,476	$ 87	40	$ 87	$	$ 652	37
38	Carpeting	1997	1,521	38	40	38		285	38
39	Railing	1997	500	13	40	13		97	39
40	Laundry / break room renovation	1998	6,864	172	40	172		1,118	40
41	Compressor	1998	917	92	10	92		598	41
42	Roof repair	1998	2,320	232	10	232		1,508	42
43	Alarm system	1998	1,056	106	10	106		689	43
44	Hospitality room renovation	1998	12,605	316	40	316		2,054	44
45	Carpeting	1998	76,503	7,653	5	7,653		84,156	45
46	Wallpaper	1998	40,287	4,026	5	4,026		44,313	46
47	Roofing	1999	208,749	20,874	10	20,874		114,807	47
48	Therapy room renovation	1999	23,731	2,374	10	2,374		13,057	48
49	Resident room lighting	1999	23,965	2,397	10	2,397		13,181	49
50	Phone upgrade	1999	2,470	248	10	248		1,364	50
51	Renovations	1999	47,385	4,738	10	4,738		26,061	51
52	New door on exygen room	1999	1,993	194	10	194		1,068	52
53	Landscaping	2000	59,350	1,484	40	1,484		6,678	53
54	Benches	2000	2,500	63	40	63		283	54
55	Room 18 renovation , wallcover, painting, tiling and carpet	2000	7,682	768	10	768		3,456	55
56	Therapy room renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		12,982	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		14,292	57
58	Common renovation, wallcover, painting, tiling and carpteing	2000	36,699	4,231	10	3,670	(561)	18,479	58
59	Kitchen renovation, wallcover, painting and tiling	2000	24,995	2,500	10	2,500		11,250	59
60	HVAC	2000	32,028	3,203	10	3,203		14,413	60
61	Doors	2000	3,300	330	10	330		1,485	61
62	Countertop	2000	654	65	10	65		293	62
63									63
64									64
65	Room renovation	2001	1,124,343	63,725	10	112,434	48,709	462,044	65
66	Rehab renovation	2001	82,557	9,808	10	8,256	(1,552)	32,776	66
67	Nurse call system	2001	114,755	11,476	10	11,476		40,166	67
68	Kitchen renovations	2001	3,800	380	10	380		1,330	68
69	HVAC	2001	3,000	300	10	300		1,050	69
70	TOTAL (lines 4 thru 69)		$ 9,529,005	$ 336,649		$ 383,245	$ 46,596	$ 4,493,403	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,529,005	$ 336,649		$ 383,245	$ 46,596	$ 4,493,403	1
2	Doors	2001	3,187	319	10	319		1,116	2
3	Office remodeling	2001	35,071	3,507	10	3,507		12,275	3
4	HVAC	2001	28,200	2,820	10	2,820		9,870	4
5									5
6	landscaping	2002	25,539	2,554	10	2,554		6,385	6
7	Fence	2002	4,675	468	10	468		1,171	7
8	Nurse Call Station Renovation	2002	26,950	2,695	40	674	(2,021)	1,685	8
9	HVAC	2002	12,424	1,242	40	311	(932)	777	9
10									10
11	Renovations	2002	33,960	3,396	40	849	(2,547)	2,122	11
12	New Therapy Addition	2002	69,218	6,922	40	1,730	(5,192)	4,482	12
13	Landscaping	2001	10,400	1,040	40	260	(780)	650	13
14	Repair R3000 System	2002	3,922		40	98	98	245	14
15	Carpeting	2002	9,713		40	243	243	607	15
16	Bathroom remodeling	2003	12,350	618	20	618		927	16
17	Wallcoverings	2003	36,922	923	40	923		1,385	17
18	Floorcoverings	2003	42,356	1,059	40	1,059		1,588	18
19	Curtains and Blinds	2003	65,815	1,645	40	1,645		2,468	19
20	Landscaping and Fencing	2003	150,886	3,772	40	3,772		5,658	20
21	Parking, Curbs, and Sidewalks	2003	276,160	6,904	40	6,904		10,356	21
22	PT Wing / New Entry / New Admin. Offices	2003	1,754,047	55,699	40	43,852	(11,847)	71,701	22
23	Signage	2003	9,043	904	10	904		1,356	23
24	Gazebo	2003	5,436	272	20	272		306	24
25									25
26	Shelving	2003	1,328	133	10	133		199	26
27	Nurse call system	2004	33,450	1,673	10	1,673		1,673	27
28	Bath tub resurfacing	2004	4,750	119	20	119		119	28
29	Alzheimer Unit Renovation	2004	77,906	974	40	974		974	29
30	Fire Alarm	2004	1,795	128	10	90	(38)	128	30
31	Lighting	2004	501	36	10	25	(11)	36	31
32	Carpet	2004	2,374	170	10	119	(51)	170	32
33	Cabinets	2004	2,626	188	10	131	(57)	188	33
34	TOTAL (lines 1 thru 33)		$ 12,270,009	$ 436,829		$ 460,289	$ 23,461	$ 4,634,020	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,270,009	$ 436,829		$ 460,289	$ 23,461	$ 4,634,020	1
2	Water heater	2004	2,997	150	10	150		150	2
3	Dentist office	2004	8,981	112	40	112		112	3
4	Expansion	2004	1,928	24	40	24		24	4
5									5
6	Allocated from Home Office	2004	689,085			17,215	17,215	44,898	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,973,000	$ 437,115		$ 477,790	$ 40,676	$ 4,679,204	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,015,762	$ 237,725	$ 302,732	$ 65,007	3-10 yrs	$ 2,530,267	71
72	Current Year Purchases	81,842	1,890	1,890		5-10 yrs	1,890	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office	599,303		77,975	77,975		316,019	74
75	TOTALS	$ 3,696,907	$ 239,615	$ 382,597	$ 142,982		$ 2,848,176	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1984 Ford Bus	1989	$ 47,590	$	$	$	5	$ 47,590	76
77	Resident care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78										78
79	Allocated from home office			28,034		2,088	2,088		5,852	79
80	TOTALS			$ 98,118	$	$ 2,088	$ 2,088		$ 75,936	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 17,107,595	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 676,730	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 862,475	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 185,746	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,603,316	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				1,546			6
7	TOTAL				$ 1,546 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C8	hrs	$	6,182	$ 342,569	$	6,182	$ 342,569	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		684	62,285		684	62,285	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		6,723	373,711		6,723	373,711	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				884,822		884,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	13,589	$ 778,565	$ 884,822	13,589	$ 1,663,387	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,200	$ 1,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 296,794)	1,910,075	1,910,075	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,000	16,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,927,275	$ 1,927,275	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	14,110,255	12,973,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,248,547	3,795,025	16
17	Accumulated Depreciation (book methods)	(7,812,767)	(7,603,316)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,904,953	$ 9,504,279	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,832,228	$ 11,431,554	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 743,177	$ 743,177	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,113	1,113	29
30	Accrued Salaries Payable	96,253	96,253	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,093	10,093	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related parties	7,766,119	7,766,119	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,616,755	$ 8,616,755	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		9,450,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,450,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,616,755	$ 18,066,755	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,215,473	$ (6,635,201)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,832,228	$ 11,431,554	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/2004**

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities		After
Line 36, Other Current Liabilities (specify):	Operating	Consolidation
Dental Withholding		
Health Insurance Withholding		
TDA Withholding		
Money Life Insurance Withholding		
Life Insurance Withholding		
Standard Withholding		
Child Support Withholding		
T.S.A. Withholding		
Misc. Payroll Withholding		
Levy		
Life Line Deposits		
Due to Related Parties		
Total	-	-

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,604,067	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustments**	(11,926)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,592,141	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(376,668)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (376,668)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,215,473	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,621,594	1
2	Discounts and Allowances for all Levels	(4,631,300)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,990,294	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,770,432	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,770,432	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	978	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	977,339	17
18	Sale of Supplies to Non-Patients	223,784	18
19	Laboratory	56,663	19
20	Radiology and X-Ray	11,743	20
21	Other Medical Services	23,446	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,293,953	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	46,576	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,576	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,101,353	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,206,631	31
32	Health Care	5,312,159	32
33	General Administration	2,570,301	33
	B. Capital Expense		
34	Ownership	1,135,799	34
	C. Ancillary Expense		
35	Special Cost Centers	1,173,091	35
36	Provider Participation Fee	80,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,478,021	40
41	**Income before Income Taxes (line 30 minus line 40)****	(376,668)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (376,668)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/2003**

Schedule 19 A

XVII. INCOME STATEMENT

E. Other Revenue

	Amount
Laundry	3,511
Day Care Income	23
Employee Meals	7,165
Telephone	12,397
Beauty/Barber Income	18,725
Miscellaneous Service Income	4,755
Total	46,576

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,024	2,088	$ 70,436	$ 33.73	1
2	Assistant Director of Nursing	1,960	2,072	54,815	26.46	2
3	Registered Nurses	20,974	22,727	697,067	30.67	3
4	Licensed Practical Nurses	14,971	15,906	370,526	23.29	4
5	Nurse Aides & Orderlies	76,528	81,174	1,483,616	18.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,394	12,518	305,305	24.39	10
11	Social Service Workers	5,909	6,303	128,316	20.36	11
12	Dietician	2,032	2,080	57,429	27.61	12
13	Food Service Supervisor	1,799	2,119	40,876	19.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	48,570	51,807	576,260	11.12	15
16	Dishwashers					16
17	Maintenance Workers	13,139	13,777	199,760	14.50	17
18	Housekeepers	15,875	17,115	180,318	10.54	18
19	Laundry	3,292	3,589	40,570	11.30	19
20	Administrator					20
21	Assistant Administrator	2,048	2,080	59,527	28.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,682	28,181	409,092	14.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,100	2,231	31,071	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	249,297	265,767	$ 4,704,984 *	$ 17.70	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 495	L1, C3	35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	4,128	L10, C3	37
38	Nurse Consultant	Monthly	4,400	L10, C3	38
39	Pharmacist Consultant	Monthly	1,740	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	22	1,078	L11, C3	44
45	Social Service Consultant	Monthly	1,958	L12, C3	45
46	Other(specify) Chapel Ministry	Monthly	210	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	22	$ 28,409		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	19,403	$ 930,759	L10, C3	50
51	Licensed Practical Nurses	3,034	122,120	L10, C3	51
52	Nurse Aides	224	3,623	L10, C3	52
53	TOTAL (lines 50 - 52)	22,661	$ 1,056,502		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine DeVries*	Administrator	0	$ 80,808
Linda Hart	Asst. Admin.	0	59,527
* Amount paid out of Home Office			
allocated in Column 7			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,335

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 876,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 876,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin		$
& Glasser LLP	Accounting	9,961
Laner, Muchin, Dombrow	Legal	7,962
Sigi, Offenbach, Pitler	Legal	500
KPMG Peat Marwick LLP	Accounting	8,800
Providence Mgmt. &		
Development Co., Inc.	Consulting	194
HRA Inc	Consulting	1,193
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,610

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,858
Unemployment Compensation Insurance	9,565
FICA Taxes	344,714
Employee Health Insurance	326,534
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Drug Testing	3,637
Uniforms	1,020
TDA Expense	87,635
Employee Welfare	27,636
Allocated from Home Office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 903,599

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 94)	799
Life Services Network	18,880
JCAHO	7,005
Miscellaneous Licenses and Dues	3,638
Miscellaneous Subscriptions	123
Allocated from Home Office	10,671
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,116

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,750
Seminar Expense	4,154
Home Office Allocation	19,639
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,543

* Attach copy of IMRF notifications

**See instructions.

Rest Haven West Christian Nursing Center
Provider #: 0028605
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	28,610
Allocated from Management Company	
Legal	1,617
Other	10,321
Total (agree to Schedule V, line 19, column 8)	40,548

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7	N/A												
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN: $18,880**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **68,876** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **80,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **8,141**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	674,565	126,278	19,642	820,485	0	820,485	0	820,485
2. Food Purchase	0	457,703	0	457,703	0	457,703	-12,395	445,308
3. Housekeeping	180,318	34,367	0	214,685	0	214,685	0	214,685
4. Laundry	40,570	79,816	0	120,386	0	120,386	-3,511	116,875
5. Heat and Other Utilities	0	0	233,142	233,142	0	233,142	12,327	245,469
6. Maintenance	199,760	0	160,470	360,230	0	360,230	-25,924	334,306
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,095,213	698,164	413,254	2,206,631	0	2,206,631	-29,503	2,177,128
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	2,707,531	260,122	1,096,542	4,064,195	0	4,064,195	0	4,064,195
10a. Therapy	0	0	778,565	778,565	0	778,565	0	778,565
11. Activities	305,305	18,132	1,078	324,515	0	324,515	0	324,515
12. Social Services	128,316	0	2,168	130,484	0	130,484	0	130,484
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,141,152	278,254	1,892,753	5,312,159	0	5,312,159	0	5,312,159
17. Administrative	59,527	0	876,000	935,527	0	935,527	-795,192	140,335
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	28,610	28,610	0	28,610	11,938	40,548
20. Fees, Subscriptions & Promotion	0	0	31,339	31,339	0	31,339	9,777	41,116
21. Clerical & General Office	409,092	25,911	29,653	464,656	0	464,656	470,428	935,084
22. Employee Benefits & Payroll	0	0	903,599	903,599	0	903,599	0	903,599
23. Inservice Training & Education	0	0	0	0	0	0	301	301
24. Travel and Seminar	0	0	5,239	5,239	0	5,239	21,304	26,543
25. Other Admin. Staff Trans	0	0	0	0	0	0	2,067	2,067
26. Insurance-Prop.Liab.Malpractice	0	0	201,331	201,331	0	201,331	13,147	214,478
27. Other (specify)*	0	0	0	0	0	0	116,173	116,173
28. Total General Adminis	468,619	25,911	2,075,771	2,570,301	0	2,570,301	-150,057	2,420,244
29. Total General Administrative	4,704,984	1,002,329	4,381,778	10,089,091	0	10,089,091	-179,560	9,909,531
30. Depreciation	0	0	676,729	676,729	0	676,729	185,746	862,475
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	437,854	437,854	0	437,854	-139,691	298,163
33. Real Estate	0	0	21,216	21,216	0	21,216	-12,256	8,960
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,546	1,546
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,135,799	1,135,799	0	1,135,799	35,345	1,171,144
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	884,822	0	884,822	0	884,822	0	884,822
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	80,040	80,040	0	80,040	0	80,040
43. Other (specify):*	0	0	288,269	288,269	0	288,269	-288,269	0
44. Total Special Cost Ce	0	884,822	368,309	1,253,131	0	1,253,131	-288,269	964,862
45. Grand Total	4,704,984	1,887,151	5,885,886	12,478,021	0	12,478,021	-432,484	12,045,537

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,200	1,200
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,910,075	1,910,075
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	16,000	16,000
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,927,275	1,927,275
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	358,918	339,570
14. Buildings, at Historical Cost	########	12,973,000
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,248,547	3,795,025
17. Accumulated Depreciation (book methods)	-7,812,767	-7,603,316
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	9,904,953	9,504,279
25. Total Assets	########	11,431,554
CURRENT LIABILITIES		
26. Accounts Payable	743,177	743,177
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,113	1,113
30. Accrued Salaries Payable	96,253	96,253
31. Accrued Taxes Payable	10,093	10,093
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	7,766,119	7,766,119
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	8,616,755	8,616,755
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	9,450,000
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	9,450,000
46.Total Liabilities	8,616,755	18,066,755
47.Total Equity	3,215,473	-6,635,201
48.Total Liabilities and Equity	########	11,431,554

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,621,594
2. Discounts and Allowances for all Levels	-4,631,300
Subtotal - Inpatient Care	6,990,294
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	3,770,432
7. Oxygen	0
Subtotal - Anciliary Revenue	3,770,432
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	978
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	977,339
18. Sale of Supplies to Non-Patients	223,784
19. Laboratory	56,663
20. Radiologyand X-Ray	11,743
21. Other Medical Services	23,446
22. Laundry	0
Subtotal - Other Operating Revenue	1,293,953
24. Contributions	0
25. Interest and Other Investments Income	98
Subtotal - Non-Operating Revenue	98
27. Other Revenue (specify):	46,576
28. Other Revenue (specify):	0
Subtotal - Other Revenue	46,576
30. Total Revenue	12,101,353
31. General Services	2,206,631
32. Health Care	5,312,159
33. General Administration	2,570,301
34. Ownership	1,135,799
35. Special Cost Centers	1,173,091
35. Provider Participation Fee	80,040
37. Other	0
40. Total Expenses	12,478,021
41. Income Before Income Taxes	-376,668
42. Income Taxes	0
43. Net Income or Loss for the Year	-376,668

Page